

# SCREENING FORM BREAST AND CERVICAL

Client Name (Last, First, MI): \_\_\_\_\_ Phone: \_\_\_\_\_ Admin Site # \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Revised

## BREAST CANCER SCREEN RESULTS

Date of Clinical Breast Exam \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Day Year

### Clinical Breast Exam (CBE) Findings

- ☐ Normal exam  
☐ Benign findings  
☐ **Abnormal: Suspicious for cancer**  
☐ CBE needed but not performed  
☐ Not done, not needed, or normal CBE in last 12 months

Date of Mammogram \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Day Year

### Mammography test results - BI-RAD Categories

- ☐ Negative - Category 1  
☐ Benign - Category 2  
☐ Probably benign, short interval f/u suggested - Category 3  
☐ **Suspicious Abnormality - Category 4**  
☐ **Highly suggestive of malignancy - Category 5**  
☐ **Assessment Incomplete - Category 0**  
☐ Mammogram needed but not performed  
☐ Not needed at this time

### Diagnostic work-up:

- ☐ Not Planned – normal Follow-up (breast screen complete)  
☐ Not Planned - short Term Follow-up (breast screen complete)  
☐ **Planned**, further diagnostic tests needed (complete abnormal form)

Next Breast Screening or follow-up due: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Year

Referred to: \_\_\_\_\_

Recommendations/Comments \_\_\_\_\_

Provider's signature: \_\_\_\_\_

Print provider's name: \_\_\_\_\_

## CERVICAL CANCER SCREEN RESULTS

### **Respond for ALL clients screened for cervical cancer:**

Has this client had a hysterectomy? ☐ Yes ☐ No

**If "Yes"** was the hysterectomy

Due to cervical neoplasia? ☐ Yes ☐ No

Or Is the cervix still present? ☐ Yes ☐ No

*NOTE: A client who has had a hysterectomy is eligible for MBCHP cervical cancer screens (Pap test) if the cervix is present, OR the hysterectomy was due to cervical neoplasia.*

### **Respond for clients with a NORMAL Pap test result:**

What is the recommended cervical cancer-screening interval for this client?

- ☐ Annual - high risk  
☐ Every 2 years - liquid base cytology  
☐ Every 3 years - 3 normal paps tests within 60 months

Date of Screening Pap test : \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Day Year

Specimen Type: ☐ Conventional ☐ Liquid

Adequacy of Specimen: ☐ Satisfactory ☐ Unsatisfactory

### **Result of Screening Pap test (cervical results only):**

- ☐ Negative for intraepithelial lesion or malignancy  
☐ ASC-US  
☐ Low Grade SIL (incl. HPV changes)  
☐ **ASC-H**  
☐ **High Grade SIL**  
☐ **Squamous Cell Carcinoma**  
☐ **Abnormal Glandular Cells**  
☐ Pap test needed but not performed  
☐ Not needed  
☐ Unsatisfactory

High Risk HPV-DNA testing done: ☐ N/A ☐ Yes ☐ No

### Diagnostic work-up:

- ☐ Not Planned – normal Follow-up (cervical screen complete)  
☐ Not Planned - short Term Follow-up (cervical screen complete)  
☐ **Planned**, further diagnostic tests needed (complete abnormal form)

Next Pap test or follow-up due: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Year

Referred to: \_\_\_\_\_

Recommendations/Comments: \_\_\_\_\_

Provider's signature: \_\_\_\_\_

Print provider's name: \_\_\_\_\_